Division of Medical Assistance
Personal Care Services Corrective Action Plan Form

Provider Name	Provider Address (site of review)	Medicaid Provider Number
_____	_____	_____
_____	_____	

I am responsible for implementation of this Corrective Action Plan. _____
Signature *Date*

☐ **Initial Corrective Action Plan**

☐ **Progress Report # ____**

Date of Initial CA Plan submission:_____

A	B	C	D	E	F	G
ID number of the deficiency (from DMA's key aspect table)	Description of deficiency	Corrective action(s) for the recipient(s) for which the service was delivered deficiently	Corrective action(s) for the agency as a whole to address deficient system issues	Person responsible for implementing the corrective action	Target dates associated with the corrective action (for recipient(s) identified in column C, correction must be no later than 60 days from date of DMA's notification letter)	Monitoring system(s) that provider plans to use to track compliance

PCS Corrective Action Plan Form
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Provider Name: _____						**Page _____**
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